The groups of glands he describes receive their lymphatics from the areas surrounding them: the occipital from the posterior part of the scalp; the mastoid from the scalp and ear; the parotid from the front of the head, the ear, and several other parts. This group is further subdivided into the superficial and deep. The former glands are served by vessels from the front of the scalp, the external ear and meatus; while the latter are connected with the orbit, nose, pharynx, middle-ear, and upper teeth. The submaxillary glands derive their lymph from the cheeks, lips, mouth, and lower teeth. Of the sterno-mastoid groups which, along with the submaxillary glands, are the most frequently affected, the upper series is connected with the tonsils, pharynx, œsophagus, and larynx; while the lower ones are related to the deeper structures and are generally found to become affected secondarily to the upper ones. The supra-clavicular are connected with the intra-thoracic and axillary glands.

The clinical importance of these relations is the fact that the cause of the enlargement is usually found to be in these regions. Glandular enlargement has always a cause, which should be sought for and removed, if possible. If the cause be not removed, the enlargement will persist, and such persistence (the open door) may give occasion to tuberculosis. Persistent enlargement, after removal of all discoverable causes, generally means tubercular infection or a pretubercular condition; therefore, all persistently enlarged glands should be excised.

Forcible Straightening of the Spine in Pott's Disease.—Two interesting cases illustrating the results of this new method of treatment are reported by MURRAY (*British Medical Journal*, December 4, 1897), with photographic illustrations of the condition found in the spine two and three months respectively after treatment.

In the first case the disease had involved three of the dorsal vertebræ, completely destroying one of them. There was not the slightest evidence of repair, but the gap formed by the straightening had resolved itself into a "false joint," bounded by caseous and diseased tissue. There was no widespread tubercular disease and the cause of death, a pneumonia, could not be attributed to the operation.

The other case had suffered from spinal disease for about two years. She died from meningitis three months after the spine had been straightened. After death her back was found to be very "wobbly" at the seat of fracture. Though the child had been kept lying since the operation—that is, for three months—there was not the least evidence of repair nor any attempt at filling-in of the gap. There was general tuberculosis, the immediate cause of death being tuberculous meningitis.

The author says, "knowing as we do the remarkable absence of new bone in tuberculous disease, the state of affairs found in the above case is in no way surprising; but, in view of these facts, it will surely be wise to stop operating for the present and await results, even if we have to wait for two or three years."

A Case of Ligature of the Innominate Artery for Aneurism.—GAY (*Boston Medical and Surgical Journal*, July 22, 1897) reports a case of ligation of the innominate artery for an aneurism which involved the innominate, subclavian, and common carotid arteries. Three ligatures of braided silk were placed upon the innominate or just above the arch, and two others together a little higher up. Through defective sterilization of the silk the field of operation was infected and a sinus formed down to the ligatures. Hemorrhage occurred on the thirty-second day. It could be controlled by pressure, and was supposed to be secondary hemorrhage from the distal end, as the carotid had been pulsating for some days. The carotid artery was ligated, but the patient continued to have repeated hemorrhages and died on the forty-second day. The autopsy showed a ruptured innominate artery on the proximal side of ligatures, with an infected wound. The aneurismal sac was obliterated except a small cavity filled with clotted blood, fibrin, and serous fluid. The subclavian artery with its branches—thyroid axis, vertebral superior intercostal and submammary—were much dilated.

Mortality and Treatment of Acute Intussusception.—From a compilation of two hundred and thirty-nine cases of acute intussusception and a study of the methods of treatment employed, GIBSON (*Medical Record*, July 17, 1897) deduces the following as the best method of treatment:

Of the symptoms nothing of much importance that is new was discovered; the most constant symptom, and one that must be considered pathognomonic when present in a child and accompanied by abdominal symptoms, is a bloody discharge from the rectum. Its absence is not, however, to be taken as evidence that intussusception does not exist. The infrequency of fecal vomiting is also noted. In general, palpation of the abdomen yields definite signs of greater value than in other forms of acute intestinal obstruction. A clearly defined tumor may, in many cases, be recognized.

The total mortality for one hundred and forty cases operated upon with antiseptic precautions is 53 per cent. The first and second days show a mortality-rate inferior to the general mortality, while the four succeeding days show a steadily increasing mortality, in each instance greater than the average. After the first week the cases merge into the subacute variety. The mortality was more than double in cases where the intussusception was irreducible, as compared with cases in which reduction was possible. The age of the patient does not apparently play so marked a rôle in regard to mortality as has been supposed, as the author finds only a 4 per cent. difference between the different classes. The author believes that the mortality is due not so much to the tender age of the majority of the patients as to the condition, also that this latter circumstance should prevent us from being sceptical of the possibility of improving our results, and lead us to discard the prevalent belief that we are dealing mainly with a class of patients whose age alone will preclude a favorable result. The author believes that an improvement in our methods of dealing with intussusception will result in decreasing the mortality. To accomplish this result we must operate at the earliest moment, and that means refraining from wasting time in attempts at reduction by inflation per rectum, except in a very limited number of cases, and such an attempt to be made only with the determination to resort to abdominal section immediately if such inflation does not at once accomplish its purpose."

In regard to treatment, the author believes that a single attempt may be made in the first twenty-four hours to reduce the intussusception by a high injection. If the condition is one of very great intensity of symptoms, it will perhaps be wisest to refrain from making such an attempt, for the reason that even on the first day reduction alone will not be sufficient treatment for the existing pathological conditions. In the second twenty-four hours, while a certain proportion of cases will yield to mechanical treatment, its usefulness becomes still more restricted, as exampled by twenty-eight cases occurring on the second day, when in four instances other procedures than reduction were found necessary.

After the second day the author believes that the possibility of relief is so small and the probability of doing harm so great that a preliminary trial of the enemata should be omitted. A small percentage of cases, which may be called the subacute variety, may in the latter days, say in the second week, offer conditions which might justify a preliminary trial of distention, where the symptoms point to a lack of severity in the local conditions, showing neither shock nor sepsis.

All preparations for operation having been made, the patient should be anæsthetized and the outlines of the intussusception carefully studied. A rectal tube should be passed, care being taken that it does not double on itself. The ingested fluid should be allowed to run in by gravity, the pressure being gradually raised. It is probably best to have the patient's pelvis well raised. The operator should keep accurate track of the result by the sense of touch. His perceptions of the results should guide his judgment as to the necessary pressure rather than actual amount, but he must remember that after attaining a hydrostatic pressure of four feet, and even less with infants, he is treading on dangerous ground. Still, here even, conditions pertaining to the individual case must be his chief guide. If, as the result of the enema, the operator can absolutely recognize by the sense of touch that the intussusception has entirely disappeared, the operation may be *postponed*. If the intussusception recurs, operation is indicated.

In operating the author advises the use of mixed anæsthesia, commencing with chloroform and changing to ether, believing that the change stimulates the patient and lessens shock.

Operation. The incision should be a median one and sufficiently long to permit of easy manipulation. If the intussusception has not been definitely located and is not immediately felt, systematic search should commence at the ileo-cæcal valve. If the cæcum is collapsed, we know that search must be directed upward. The intussusception having been found, it should be examined by inspection over its whole extent. The first glance may show that reduction is impossible or unwise. Attempts at reduction are best made in the direction of working the sheath away from the invagination rather than pulling the latter out; such a procedure often causes excessive tears of the gut at some adherent point. The abdominal cavity should be protected by pads. Should reduction be accomplished the gut should be carefully examined for any point of impaired vitality. If in doubt, gauze packing may be placed about the intestines, and sutures inserted in the abdominal wound, but not tied. Twenty-four hours will determine the question when the appropriate measures may be taken. If the intestine cannot be reduced, its vitality must be determined. This is a point that requires great judgment. If there is doubt, treat it as the gangrenous variety.

The methods of treatment open to the operator are artificial anus, entero-anastomosis, partial resection, and typical resection. The artificial anus should be reserved for those cases whose general condition is so desperate that any further procedures must necessarily be attended by death. This is, however, true only of the small intestine, the large intestine offering better chances, though here the mortality is 50 per cent. of deaths following upon the operation.

Entero-anastomosis is a method that may be employed. Partial or atypical resection, or resection of the intussusception through an incision in the sheath, is an operation that is, under favoring conditions, simple and speedy. and sacrifices less intestine than a typical resection. Resection of the entire intussusception is probably more dangerous than the operation just mentioned, and will be employed less frequently the more generally the other form becomes known. It is preferable to the others when in entero-anastomosis there is hesitation at leaving a considerable portion of the gut to "take care of itself," or (rarely) technical difficulties in performing the entero-anastomosis, for resection of the invagination, failure to separate from adhesions, for either procedure if there is any suspicion relative to the non-septic condition of the intestines.

For the treatment of gangrenous intussusception the author recommends only: 1. Resection with immediate union of the divided intestine. 2. Resection with utilization of the divided ends for a temporary artificial anus.

The indications for one or the other operation are dependent upon the condition of the patient.

In after-treatment shock from loss of heat must be guarded against by keeping the patient warm in all stages and avoiding contact with moist cloths. Alcohol subcutaneously is advocated as one of the best stimulants, while strychnine is the drug next in importance. Camphor dissolved in olive oil is a most valuable subcutaneous agent. The subcutaneous injection of saline solutions is also favorably mentioned.

The Forcible Correction of the Deformity of Pott's Disease.—MENARD (*La Press Méd.*, No. 57, 1897), after a careful study of the effect of this method of reduction upon a number of cases in post-mortems, and a careful review of the respirative process as seen in pathological specimens, says that the method must be considered wrong if applied to all forms of Pott's disease irrespective of their situation and volume. It is impossible to estimate the consequences, and the greatest caution should be maintained in expressing an opinion as to the future usefulness of the methods.

It is impossible to calculate the accidents which may follow upon this forcible reduction. The result of this procedure upon the tubercular focus is not known; all that can be said is that in all other parts of the body traumatism aggravates osteo-arthritic tubercular disease, and occasionally gives rise to the formation of abscesses. One cannot be far from wrong in predicting grave complications as the result of this treatment. It is the general rule that no new bone is formed in the reparative process subsequent to tubercular disease of the vertebræ. There is nothing to authorize the belief